mindalive inc

david

[PERSONAL PROFILE]

Questionnaire and Getting Started Guide

Version 1, Revision 6
May 2019

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https://mindalive.com/manuals/

GETTING STARTED

COMPLETING THE PERSONAL PROFILE QUESTIONNAIRE

The purpose of this questionnaire is to give you a sense of how your stress level, sleep patterns, nutrition, and other factors may be influencing your mind and ultimately your quality of life. By quantifying your concerns, this questionnaire can illuminate certain areas which may require adjustment, and help you to decide which AVE stimulation category will be of most benefit to you.

HOW TO USE THE PERSONAL PROFILE QUESTIONNAIRE

Fill out the personal profile questionnaire found in the second half of this guide. Follow the instructions carefully, then, tally your scores in each section to discover which *Session Group* is best for you.

FOR YOUR FIRST DAVID EXPERIENCE, WE USUALLY RECOMMEND THAT YOU TRY AN "ALPHA BRAINWAVE" SESSION, SUCH AS THOSE FOUND IN THE MEDITATION CATEGORY. YOU MAY EVEN WANT TO TRY A FEW MEDITATION SESSIONS DURING YOUR FIRST WEEK, BEFORE MOVING ON TO THE SESSION GROUP SUGGESTED BY THE QUESTIONNAIRE.

ADDITIONAL RESOURCES

AVE Session & Protocol Guide for Professionals – by Dave Siever

AVE and Nutrition articles by Dave Siever, CET – Available online at https://mindalive.com/articles/

PERSONAL PROFILE QUESTIONNAIRE

Prepared by Brain Gym PR March, 2012

I. REST

1) How many hours do you sleep at night approximately?

   ☐ less than 3 hours
   ☐ 4-6 hours
   ☐ 7-9 hours

2) Do you sleep all night long without interruptions or sleeplessness?

   ☐ Yes
   ☐ No

3) When you lay down to sleep, do you fall asleep within the first half hour?

   ☐ Yes
   ☐ No

4) Do you take any medication for sleep?

   ☐ Yes Which one? _____ Since when? _____
   ☐ No

5) Do you find yourself dwelling on a particular concern or worry that interferes with your sleep?

   ☐ Yes. Specify: _____
   ☐ No

6) When you wake up, do you feel tired?

   ☐ Always
   ☐ Often
   ☐ Sometimes
   ☐ Rarely

II. LIFE EVENTS & SELF AWARENESS

*Indicate any situation that has occurred to you within the **last year***
(or those which have happened to somebody very close to you).

- ☐ Divorce /Separation
- ☐ Loss of employment
- ☐ Change of duties at work
- ☐ Change of a supervisor
- ☐ Problems with the law
- ☐ Change of financial status
- ☐ Difficulty raising children
- ☐ Disease or Hospitalization
- ☐ Pregnancy or birth of a child
- ☐ Reconciliation
- ☐ Change of residence
- ☐ Economic problems
- ☐ Beginning a new job
- ☐ Beginning a new relationship
- ☐ Death of a relative (relation: _____)
- ☐ Other(s)_____

_____

_____

_____

_____

_____

PERSONAL PROFILE QUESTIONNAIRE

III. ANXIETY

*Read carefully and identify the symptom(s) that you have felt during the **last month**. Circle one of the numbers next to every symptom that relates to the frequency that you perceive that symptom.*

0: Never
1: Rarely
2: Some of the time
3: Most of the time
4: Constant/Overwhelming

Symptoms	**Frequency**				
Nagging thoughts	0	1	2	3	4
Negative thoughts or feelings about yourself	0	1	2	3	4
Feeling insecure	0	1	2	3	4
Fear that someone will notice your anxiety and to what might happen if it is noticed	0	1	2	3	4
Upset stomach	0	1	2	3	4
Sweating / Perspiration	0	1	2	3	4
Tremors or shakiness	0	1	2	3	4
Muscle tension and discomfort	0	1	2	3	4
Palpitating or racy heart	0	1	2	3	4
Constant squirming (feet, hands, scratching, etc.)	0	1	2	3	4
Smoking, eating or drinking in excess	0	1	2	3	4
Avoiding social situations	0	1	2	3	4
Sensation of breathlessness	0	1	2	3	4
Feeling annoyed	0	1	2	3	4
Feeling irritable	0	1	2	3	4
Difficulty concentrating or maintaining focus	0	1	2	3	4

IV. MOOD

*Identify the symptom(s) that you have felt during the **last two weeks**. Circle one of the numbers next to every symptom that relates to the frequency at which you perceive that symptom.*

0: Never
1: Some of the time
2: Most of the time
3: Constant/Overwhelming

Symptoms	**Frequency**			
Feelings of sadness	0	1	2	3
Feeling pessimistic	0	1	2	3
Feeling like a failure	0	1	2	3
Lack of pleasure	0	1	2	3
Feelings of guilt	0	1	2	3
Feelings of being punished by life	0	1	2	3
Self-critical	0	1	2	3
Thoughts of self-harm or suicide	0	1	2	3
Weeping or crying	0	1	2	3
Restlessness	0	1	2	3
Lack of interest in most everything	0	1	2	3
Difficulty in making decisions	0	1	2	3
Lack of self-appreciation	0	1	2	3
Lack of energy	0	1	2	3
Irritability	0	1	2	3
Changes in sleeping pattern	0	1	2	3
Changes of appetite	0	1	2	3
Difficulty with concentration	0	1	2	3
Fatigue	0	1	2	3
Loss of interest in sex	0	1	2	3

PERSONAL PROFILE QUESTIONNAIRE

V. DISENGAGEMENT

*Read carefully and identify the symptom(s) that you have felt during the **past year**. Circle one of the numbers next to every symptom that relates to the frequency that you perceive that symptom.*

0: Never
1: Some of the time
2: Most of the time
3: Constant/Overwhelming

Symptoms	Frequency			
Difficulty paying close attention to details	0	1	2	3
Difficulty sustaining attention in tasks	0	1	2	3
Difficulty organizing tasks and activities	0	1	2	3
Avoiding tasks that require mental effort	0	1	2	3
Losing things necessary for tasks or activities	0	1	2	3
Easily distracted	0	1	2	3
Difficulty following instructions and making mistakes	0	1	2	3
Forgetful in daily activities	0	1	2	3
Fidgets with hands or feet or squirms in seat	0	1	2	3
Always "on the go"	0	1	2	3
Interrupts or intrudes on others	0	1	2	3
Difficulty waiting for one's turn	0	1	2	3
Often late for events and appointments	0	1	2	3

VI. MEDICATIONS

*Make a list of the drugs that you are taking or have taken in the **last 6 months**:*

Condition	Medication
Diabetes	
Thyroid	
ADD/ADHD	
Hypertension	
Asthma	

1) What have you done to feel better?

_____

_____

_____

2) Have you visited a doctor, specialist or have you been in the emergency room due to any of these symptoms?

☐ Yes
☐ No

If Yes, what was done to help you feel better?

_____

_____

_____

VII. NUTRITION

1) Do you include fresh fruits and vegetables in your diet?

☐ No ☐ Yes How much? _____

7) Do you eat green leaves or seaweed?

☐ No ☐ Yes How much? _____

8) Approx. how many cups of water do you drink daily? _____

9) Does your diet contain artificial colors, preservatives or additives?

☐ No ☐ Yes

10) Do you drink sodas or carbonated drinks?

☐ No ☐ Yes How many cans/bottles daily?_____

11) Do you drink coffee or caffeinated drinks?

☐ No ☐ Yes How many cups per week? _____

12) Do you smoke cigarettes or marijuana?

☐ No ☐ Yes How many per week? _____

13) Do you drink alcohol?

☐ No ☐ Yes How many drinks per week? _____

14) Do you use white sugar and/or products with refined flours?

☐ No ☐ Yes

15) Do you need comfort foods (chocolate, fried food, red meat, etc.)

☐ No ☐ Yes What foods? _____

16) Do you take vitamin supplements?

☐ No ☐ Yes

PERSONAL PROFILE INTERPRETATION

I. REST

This helps to determine if you have particular worries or perhaps nutritional/health issues, which may be interfering with your sleep.
See Page 13 for more information.

II. LIFE EVENTS & SELF AWARENESS

Depending on the stressors and changes in daily life, mainly during the last 6 months. You could be experiencing a clinical disorder or adaptive behaviour with anxiety, depression or mixed mood. Consult with a psychologist or counselor if you have concerns.

III. ANXIETY

Total Scores	Result
0 – 15 points	Minimum anxiety
16 – 20 points	Slight anxiety
21 – 30 points	Symptoms of moderate anxiety Consider consulting a psychologist
31 – 64 points	Symptoms of severe anxiety Consider consulting a psychologist

IV. MOOD

Total Scores	Result
0 – 13 points	Minimum depressive symptoms
14 – 19 points	Slight depressive symptoms
20 – 28 points	Moderate depressive symptoms
29 – 63 points	Severe depressive symptoms Consider consulting a psychologist

V. DISENGAGEMENT

Total Scores	Result
0 – 13 points	Inattention Possible mild ADD.
14 – 20 points	Hyperactive Possible mild ADD/ADHD.
21 – 30 points	Hyperactive Possible moderate ADD/ADHD
31 – 39 points	Very hyperactive Severe ADHD.

An under-engaged mind over several years could be an indication of ADD or ADHD (hyperactivity). If the symptoms have been of shorter duration, it could be an indication of stress, depression, poor nutrition or eating a typical sugary breakfast.

VII. NUTRITION

Evaluate your nutritional habits. Proper nutrition is a critical factor in overall mental and physical health. Refer to our nutrition articles online for more information. Consult with your physician or dietician if necessary.

CHOOSING A DAVID SESSION

Look at the categories and determine which category is of most concern. It is possible that two or three categories might be of concern.

III. Anxiety – Use the Meditation and/or Feeling Better category. Also consider the SLEEP sessions for improved sleep.

IV. Mood – Use the Feeling Better and/or Meditation category.

V. Disengagement– Use the Brain Brightener and/or Energizer category.

Sessions from more than one category may be alternated. For instance, you can use an Energizer session one day and a Brain Brightener the next. Or alternate between the Feeling Better and the Meditation. The Brain Brightener, Depression and Energizer sessions are best used in the morning. The Meditation sessions are best used after lunch.

This is a guideline only. You will discover which times work best for you.

ENERGIZER SESSIONS

These are best used upon wakening, as they have a tendency to wake a person up and can be a replacement for coffee. However, those with ADD/ADHD will often fall completely asleep and wake up completely relaxed. So, even though we recommend these sessions be used only in the morning or as an energy boost for an evening of socializing, those with ADD/ADHD will often benefit from using Energizer sessions to fall asleep with and can run the session while in bed.

MEDITATE

The meditate sessions are designed to bring down arousal levels associated with frantic, unsettled thoughts and stress. They can be used at any time of day.

BRAIN BRIGHTENER

These are generally best used in the morning upon wakening. They have been shown to boost concentration and memory.

MOOD BOOSTER

These sessions have been proven to reduce depressed feelings and will increase happiness. They will also boost logical thinking and organizational abilities. They are best used upon awakening as a way to start your day with a happy disposition. However, they often work at bedtime for falling asleep.

SLEEP

These are best used at bedtime and not at the start of your day. For anyone on a modified sleep schedule (such as shift workers), this may be in the AM, before falling asleep

The low-frequency sessions such as Schumann, Paradise, Alpha-Theta are best used when the issue involves a busy mind AND a tense body. As most tense people are not often aware as to just how tense they are, always start with this one. The SMR Sleep is for those who have a busy mind only and their body is quite relaxed. People will generally begin with the low-frequency type and as the AVE relaxes their body, they have to move to the SMR type in a few weeks.

IS MY INSOMNIA CAUSED BY STRESS OR A NUTRITIONAL ISSUE?

Good nutrition is absolutely necessary for good brain function! This is very important in relation to sleep. To determine if you have a sleeping problem that is caused by inadequate nutrition, first ask yourself this VERY important question:

Is there a recurring theme? In other words, is your mind filled with thoughts of issues with your mate, or a divorce, or worries about assignments or an upcoming exam? You might have money issues or be concerned about something you saw in the news, the environment, poor health or personal crisis.

The point is, when you cannot sleep, are your thoughts filled with a recurring theme? If so, you have stress issues and the DAVID can help soothe the brain from those thoughts.

If your thoughts are just a bunch of random nonsense, then it's likely that your brain won't settle down due to nutritional issues. The following supplements almost always reduce and often eliminate insomnia:

1) Vitamin D^3
2) Omega 3s
3) Minerals - particularly magnesium
4) B complex

Refer to our nutrition articles online for more information.

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